Medicaid and the Health Insurance Exchange

In January 2014, lower- and middle-income Nevadans with family income up to four times the Federal Poverty Level (FPL) may be eligible for subsidized health coverage through the expansion of Medicaid and the establishment of the Health Insurance Exchange. Non-elderly residents with modified adjusted gross income (MAGI) up to 138 percent of the federal poverty level will be eligible for Medicaid, and residents with income between 139 and 400 percent FPL may be eligible for premium subsidies for health insurance purchased through the Exchange.[1]

Individuals and families eligible for Medicaid will not be charged a monthly premium, while coverage through the Exchange will require the member to pay a premium ranging from 3.0% of MAGI for individuals and families at 139% FPL to 9.5% of MAGI for households with MAGI between 300% and 400% FPL. [2] The chart below displays the income limits, based on 2011 FPL percentages, for Medicaid and the Exchange, based on household size. The two columns on the right of the chart display the range of monthly premiums for health coverage purchased through the Exchange.

Family Size	Medicaid Eligibility Income Limit (up to 138% FPL)	Exchange Eligibility Income Limit (up to 400% FPL)	Monthly Premiums for Health Insurance Purchased Through the Exchange -- Based on Income and Percentage of FPL	
			3.0% of Income	9.5% of Income
One	$15,028	$43,560	$38	$345
Two	$20,300	$58,840	$51	$466
Three	$25,571	$74,120	$64	$587
Four	$30,843	$89,400	$77	$708
Five	$36,115	$104,680	$90	$829

As Nevada continues to plan for the full implementation of the federal Patient Protection and Affordable Care Act (ACA), the State will need to coordinate a number of activities across Medicaid, Nevada Check-Up (the State's Children's Health Insurance (CHIP) Program), and the Exchange. This issue brief focuses on four key areas of interaction between Medicaid, Nevada Check-Up and the Exchange; (1) outreach, education and enrollment; (2) covered benefits; (3) provider networks; and (4) health carriers.

[1] Premium subsidies available through the Exchange will be provided by the federal government in the form of advanced tax credits that will be sent directly on the member's behalf to the enrollee's health insurance carrier.
[2] Individuals and families with income in excess of 400 percent FPL will also be eligible to purchase coverage through the Exchange, but they will not have access to federally-funded premium subsidies.

Outreach, Education and Enrollment

The ACA requires states to establish a single, streamlined eligibility and enrollment process that will serve as the central point of access to all subsidized health coverage programs, including Medicaid, Nevada Check-Up and the Exchange. The Exchange is also the point of entry for individuals seeking to purchase private coverage without a subsidy. Nevada has already started working to modify its existing eligibility processes for Medicaid, with the goal of establishing a single eligibility system for Medicaid, Nevada Check-Up and the Exchange.

In addition to this single point of entry, people will need assistance assessing their health coverage options and completing the enrollment process. The State will need to develop a multi-pronged outreach, education and enrollment program. Such an effort may include a number of organizations and individuals, including the Exchange, Medicaid and other social service agencies, Division of Insurance, Governor's Office of Consumer Health Assistance (GovCHA), schools, community groups, faith based organizations, private employers, business groups, hospitals, community health centers, physicians, health insurers, brokers and agents, paid media, and public service announcements.

In addition to establishing a Web site, customer service unit and call center, as well as walk-in centers to help people with the eligibility and enrollment process, the Exchange will need to contract with outside entities (i.e., "Navigators") that can assist individuals with eligibility and enrollment for all health coverage programs. Navigators, pursuant to the ACA, will be responsible for:

- Conducting public education activities to raise awareness of the availability of qualified health plans through the Exchange;
- Distributing information on enrollment and the availability of premium subsidies and cost-sharing reductions;
- Facilitating enrollment in qualified health plans;
- Referring people to the appropriate agency or agencies if they have questions, complaints, or grievances; and,
- Providing information in a culturally and linguistically appropriate manner.

Nevada currently relies on community-based groups to help with outreach and enrollment for Medicaid, Nevada Check-Up, and other public assistance programs, and these groups may be ideal candidates to become Nevada Exchange Navigators. In addition, the Exchange will need to expand outreach efforts beyond these groups, in part due to the need to reach people who normally are not eligible for public assistance programs (i.e., individuals and families with income up to 400 percent FPL). The Exchange will need to establish a selection process for awarding grants to Navigators, and it will likely need to coordinate its outreach, eligibility and enrollment efforts with Medicaid and Nevada Check-Up. Leveraging the experience and expertise of various parties – including State agencies, county social service agencies, community-based organizations, and other entities – will be crucial to the development of an efficient and effective outreach, education and enrollment program.

Covered Benefits

Health plans offered through the Exchange must cover "essential health benefits" (discussed further below), which will be available in five benefit levels or tiers of coverage: Platinum, Gold, Silver, Bronze, and Catastrophic. While the benefits package (i.e., what is covered) will likely be the same across each of the plan levels, the plan levels will have different amounts of point-of-service cost sharing (i.e., deductibles, co-payments, co-insurance). Platinum level plans will have the lowest cost sharing and the highest premiums, while Catastrophic plans will have the greatest amount of cost sharing and the lowest premiums.

Just as the monthly premiums for individuals and families eligible for federal premium subsidies will vary based on the households' annual income (i.e., MAGI), cost sharing (i.e., the out-of-pocket maximum) will also vary based on MAGI. The table below displays the out-of-pocket limits for Exchange plans based on the enrollee's MAGI.

Income Category	Reduction in Out-of-Pocket Limit Relative to HSA/HDHP Maximum[3]	Out-of-Pocket Limit (based on 2011 HSA/HDHP Maximum for Individuals/Families)	Actuarial Value of Silver Level Plan
Up to 150% FPL	Reduced by two-thirds	$1,963/$3,927	94%
150.1 – 200% FPL	Reduced by two-thirds	$1,963/$3,927	87%
200.1 – 250% FPL	Reduced by one-half	$2,975/$5,950	73%
250.1 – 300% FPL	Reduced by one-half	$2,975/$5,950	70%
300.1 – 400% FPL	Reduced by one-third	$3,986/$7,973	70%
Above 400% FPL	No reduction	$5,950/$11,900	70%

Nevada residents who will become newly eligible for Medicaid as a result of the eligibility expansion will be guaranteed, at a minimum, a "benchmark benefits" package. A benchmark benefits package allows states to provide certain groups of Medicaid enrollees with benefits that may be slightly different from the standard Medicaid benefits package.

Under this approach, the benchmark benefits package may be based on one of three commercial insurance products or a benefit package approved by the U.S. Secretary of Health and Human Services, and that covers the "essential health benefits," discussed below.

The major federal rules governing benchmark coverage include the following:

1. Benchmark and benchmark-equivalent plans must cover all of the essential health benefits, which include:

[3] Pursuant to the ACA, health plans sold through the Exchange must include an out-of-pocket maximum. The amount of the out-of-pocket maximum will be governed by the limits that apply to high deductible health plans (HDHP), which are set annually by the Internal Revenue Service (IRS).

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management;
- Pediatric services, including oral and vision care; and
- Early Periodic Screening and Developmental Services (EPSDT).[4]

The Secretary of Health and Human Services will issue regulations to further define what constitutes essential health benefits. The exclusion of long-term care (i.e., nursing home coverage) may be the most significant difference between a benchmark benefit and traditional Medicaid.

2. Coverage must be equal to the coverage provided in one of three benchmarks, equivalent in actuarial value to one of three benchmarks, or a package approved by the Secretary (i.e., benchmark-equivalent). The three benchmark plans are:

   I. The standard Blue Cross/Blue Shield preferred provider plan offered by the Federal Employees Health Benefits Plan (FEHBP);
   II. A health plan offered to State employees; or
   III. A managed care plan with the largest commercial, non-Medicaid enrollment in the State.

The State can choose to provide additional benefits on top of what is required in a benchmark-equivalent plan, as long as the services are included in the benchmark plan or could be covered under the standard Medicaid benefits package.

3. Benchmark and benchmark-equivalent coverage must meet other Medicaid requirements, including requirements to cover transportation services, family planning services, and care provided by rural health clinics and federally qualified health centers (FQHCs). Also, such coverage, if it is provided through managed care entities, must comply with Medicaid

[4] Health plans available through the Exchange will also be required to cover all of the essential health benefits, with the exception of EPSDT services, which are required to be covered by Medicaid.

managed care requirements. In addition, states must secure public input prior to filing a proposal with HHS to use benchmark or benchmark-equivalent coverage.

As Nevada develops the health benefits package for individuals who will become newly eligible for Medicaid, as well as the health benefits that will be provided by health insurers offered through the Exchange, the State will need to consider the extent to which benefits can be aligned across these health coverage programs.

Provider Networks

The expansion of Medicaid eligibility and the availability of premium subsidies for health insurance purchased through the Silver State Health Insurance Exchange provide an opportunity for Nevadans who currently may not be able to afford health insurance to gain access to affordable coverage. In addition to aligning benefits and services across these programs, Nevada Medicaid and the Exchange might also consider the extent to which physicians and hospitals are participating in the provider networks of the Exchange's health plans and the Medicaid program's Managed Care Organizations (MCOs).

Because eligibility for these health coverage programs will be determined throughout the year, some enrollees will be eligible for Medicaid for part of the year and for the Exchange for part of the year. This will occur due to changes in family composition (e.g., marriage, birth of a child, divorce) and income. One national estimate suggests that as many as 50 percent of enrollees may shift between the Medicaid program and the Exchange during the year.[5]

As people move across these programs, ensuring as much continuity of care as possible, with regard to the patient-physician relationship and access to hospitals, will be a key consideration for the Exchange and for the Medicaid program.

In developing criteria to certify qualified health plans, the Silver State Health Insurance Exchange could encourage health carriers to include, to the greatest extent possible, physicians and hospitals that also participate in the Medicaid program and are part of the MCOs' provider networks. In fact, one of the criteria in the ACA pertaining to the Exchange's certification of qualified health plans involves the inclusion of "essential community providers," including FQHCs and disproportionate share hospitals (DSH), among others.

In addition, the State's Medicaid program may wish to evaluate the MCOs' provider networks to determine the extent to which physicians and hospitals are also part of the Exchange's health plans' provider networks. Exchange health plans and Medicaid MCOs that have overlapping provider networks can help minimize the potential disruption in care that may occur as people shift from the Exchange to Medicaid and vice versa.

[5] "Issues in Health Reform: How Change in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," Benjamin D. Sommers and Sara Rosenbaum, Health Affairs, February 2011.

Health Carriers

A fourth issue that may affect the continuity of coverage and the ability of people to successfully navigate the health programs that will be available in 2014 involves the health carriers that will be available through the Exchange and the State's Medicaid program. Currently, the State contracts with two MCOs – Amerigroup and Health Plan of Nevada – to serve Medicaid members residing in Nevada's two urban areas, Clark and Washoe Counties. Medicaid recipients living outside of these two metropolitan areas, as well as Medicaid recipients who are aged, blind or disabled, are provided benefits in a fee-for-service arrangement and are not enrolled in an MCO.

The Exchange will be responsible for certifying qualified health plans. Much like the preceding discussion regarding provider networks, a policy consideration for both the Exchange and the State's Medicaid administrators involves efforts to encourage health carriers to serve both markets. The implementation of health reform may increase Nevada's Medicaid enrollment by as much as 145,000 people,[6] which may result in new carriers entering the Medicaid MCO market.

At the same time, with premium subsidies and reduced cost sharing available through the Exchange, as many as 200,000 Nevada residents, or more, who currently lack coverage may purchase federally-subsidized health insurance through the Exchange.[7] This may encourage the Medicaid MCOs to develop commercial insurance products that may be offered through the Exchange. Providing an option for people to remain with a health carrier as their eligibility changes between Medicaid and the Exchange may be a worthwhile consideration to improve coordination between these programs.

In addition, because Nevada Check-Up eligibility extends to children in families with income at or below 200% FPL, there will likely be a number of children covered by Nevada Check-Up whose parents are covered through the Exchange. Coordinating coverage for these "split" families could be improved by encouraging health plans to serve all of Nevada's publicly-subsidized health coverage programs.

Key Issues for Nevada

The roll-out of the Silver State Health Insurance Exchange and the expansion of Medicaid should enable hundreds of thousands of Nevadans to access affordable health coverage. In implementing these programs, a number of key decisions will need to be addressed as the State seeks to establish comprehensive health coverage programs that will work best for Nevadans.

- How can the State establish a streamlined eligibility determination process that will enable residents to apply for all medical assistance programs through a single application?

[6] "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on Exchanges and Medicaid," Matthew Buettgens, John Holohan and Caitlin Carroll, March 2011.
[7] Buettgens, Hollohan and Carroll, March 2011.

- What types of outreach and education will be necessary to reach different groups of people who will become newly eligible for Medicaid and for premium subsidies for commercial insurance available through the Exchange?

- What organizations and entities can the Exchange leverage to assist with outreach, education and enrollment?

- What types of benefits and services should be made available to individuals and families who will become newly eligible for Medicaid as a result of the 2014 expansion?

- How can the benefits in the Exchange align with the Medicaid benefits to provide for a continuum of coverage as people move between these programs?

- How can the State and the Exchange encourage providers to participate in the Medicaid MCOs' and commercial insurance plans' provider networks?

- How can the State and the Exchange entice existing Medicaid MCOs to offer a commercial insurance product and/or entice commercial insurers to offer a Medicaid product?

- Can the State and the Exchange develop a unified purchasing strategy for Medicaid beneficiaries and qualified health plans offered through the Exchange?